

		FOR OHF USE					

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**2002**  
**STATE OF ILLINOIS**  
**DEPARTMENT OF PUBLIC AID**  
**FINANCIAL AND STATISTICAL REPORT FOR**  
**LONG-TERM CARE FACILITIES**  
**(FISCAL YEAR 2002)**

IMPORTANT NOTICE  
 THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION  
 THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY  
 PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE  
 OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE  
 ANY INFORMATION ON OR BEFORE THE DUE DATE WILL  
 RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM  
 HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<b>I. IDPH Facility ID Number:</b> <u>0032045</u>		<b>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</b>	
<b>Facility Name:</b> <u>Daystar Care Center</u>		<b>I have examined the contents of the accompanying report to the</b> <b>State of Illinois, for the period from</b> <u>01/01/2002</u> <b>to</b> <u>12/31/2002</u> <b>and certify to the best of my knowledge and belief that the said contents</b> <b>are true, accurate and complete statements in accordance with</b> <b>applicable instructions. Declaration of preparer (other than provider)</b> <b>is based on all information of which preparer has any knowledge.</b>	
<b>Address:</b> <u>2001 Cedar Street</u> <u>Cairo</u> <u>62914</u> Number City Zip Code		<b>Intentional misrepresentation or falsification of any information</b> <b>in this cost report may be punishable by fine and/or imprisonment.</b>	
<b>County:</b> <u>Alexander</u>		<b>Officer or Administrator of Provider</b> (Signed) _____ (Date) _____	
<b>Telephone Number:</b> <u>618-734-1700</u> <b>Fax #</b> <u>618-734-2611</u>		(Type or Print Name) <u>Amy Keistler</u>	
<b>IDPA ID Number:</b> <u>37-1088946</u>		(Title) <u>Administrator</u>	
<b>Date of Initial License for Current Owners:</b> <u>07/17/1987</u>		(Signed) _____ (Date) _____	
<b>Type of Ownership:</b>		<b>Paid Preparer</b> (Print Name and Title) <u>David D. Seabaugh, CPA</u> <u>Partner</u>	
<input checked="" type="checkbox"/> <b>VOLUNTARY, NON-PROFIT</b> <input checked="" type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust <b>IRS Exemption Code</b> <u>501 (c)(3)</u>		(Firm Name & Address) <u>Beussink, Hey, Roe, Seabaugh &amp; Stroder, L.L.C.</u> <u>P.O. Box 167, Cairo, IL 62914</u>	
<input type="checkbox"/> <b>PROPRIETARY</b> <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____		(Telephone) <u>618-734-3300</u> <b>Fax #</b> <u>618-734-3303</u>	
<input type="checkbox"/> <b>GOVERNMENTAL</b> <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____		<b>MAIL TO: OFFICE OF HEALTH FINANCE</b> <b>ILLINOIS DEPARTMENT OF PUBLIC AID</b> <b>201 S. Grand Avenue East</b> <b>Springfield, IL 62763-0001</b> <b>Phone # (217) 782-1630</b>	
<b>In the event there are further questions about this report, please contact:</b> <b>Name:</b> <u>Amy Keistler</u> <b>Telephone Number:</b> <u>618-734-1700</u>			

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 2

Facility Name & ID Number Daystar Care Center# 0032045 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds 04/18/1990

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>83</u>	Skilled (SNF)	<u>83</u>	<u>30,295</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>83</u>	TOTALS	<u>83</u>	<u>30,295</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>1,682</u>	<u>160</u>	<u>3,571</u>	<u>5,413</u>	8
9	SNF/PED					9
10	ICF	<u>19,065</u>	<u>920</u>	<u>201</u>	<u>20,186</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>20,747</u>	<u>1,080</u>	<u>3,772</u>	<u>25,599</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 84.50%D. How many bed-hold days during this year were paid by Public Aid?  
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)NoneF. Does the facility maintain a daily midnight census? YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?  
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?  
YES ☒ NO ☐I. On what date did you start providing long term care at this location?  
Date started 07/22/1987

J. Was the facility purchased or leased after January 1, 1978?

YES ☐ Date \_\_\_\_\_ NO ☒

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter number  
of beds certified 17 and days of care provided 3,237Medicare Intermediary IVANS

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 1/1 to 12/31/02 Fiscal Year: 1/1 to 12/31/02

\* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number

Daystar Care Center

# 0032045

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

**V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)**

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	136,276	7,101	6,675	150,052	(23,164)	126,888		126,888		1
2	Food Purchase		114,424		114,424	(17,718)	96,706		96,706		2
3	Housekeeping	88,343	14,172		102,515		102,515		102,515		3
4	Laundry	56,274	21,916		78,190		78,190		78,190		4
5	Heat and Other Utilities			90,246	90,246		90,246		90,246		5
6	Maintenance	36,112	7,112	15,886	59,110		59,110	(4,501)	54,609		6
7	Other (specify):*										7
8	<b>TOTAL General Services</b>	317,005	164,725	112,807	594,537	(40,882)	553,655	(4,501)	549,154		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			3,600	3,600		3,600		3,600		9
10	Nursing and Medical Records	948,045	146,089	13,396	1,107,530		1,107,530		1,107,530		10
10a	Therapy	72,876	1,399	116,569	190,844		190,844		190,844		10a
11	Activities	49,207	2,653		51,860		51,860	(1,783)	50,077		11
12	Social Services	42,311	54	3,224	45,589		45,589		45,589		12
13	Nurse Aide Training										13
14	Program Transportation			2,582	2,582		2,582		2,582		14
15	Other (specify):*			4,200	4,200		4,200		4,200		15
16	<b>TOTAL Health Care and Programs</b>	1,112,439	150,195	143,571	1,406,205		1,406,205	(1,783)	1,404,422		16
	<b>C. General Administration</b>										
17	Administrative	39,379			39,379		39,379		39,379		17
18	Directors Fees										18
19	Professional Services			25,026	25,026		25,026		25,026		19
20	Dues, Fees, Subscriptions & Promotions			8,249	8,249		8,249	(525)	7,724		20
21	Clerical & General Office Expenses	112,332	11,903	29,468	153,703		153,703	(834)	152,869		21
22	Employee Benefits & Payroll Taxes			152,059	152,059	38,300	190,359	(10,131)	180,228		22
23	Inservice Training & Education										23
24	Travel and Seminar			2,873	2,873		2,873		2,873		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			70,015	70,015		70,015		70,015		26
27	Other (specify):* non-allowable meals					2,582	2,582	(2,582)			27
28	<b>TOTAL General Administration</b>	151,711	11,903	287,690	451,304	40,882	492,186	(14,072)	478,114		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	1,581,155	326,823	544,068	2,452,046		2,452,046	(20,356)	2,431,690		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name & ID Number Daystar Care Center

#0032045

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation				106,662		106,662		106,662			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			87,906	87,906		87,906	(895)	87,011			32
33	Real Estate Taxes			21	21		21	(21)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	<b>TOTAL Ownership</b>			87,927	194,589		194,589	(916)	193,673			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops		7,589		7,589		7,589		7,589			41
42	Provider Participation Fee			45,443	45,443		45,443		45,443			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		7,589	45,443	53,032		53,032		53,032			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	1,581,155	334,412	677,438	2,699,667		2,699,667	(21,272)	2,678,395			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Daystar Care Center

# 0032045

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	1	2	3	
	Amount	Refer-	OHF USE	
NON-ALLOWABLE EXPENSES		ence	ONLY	
1 Day Care	\$		\$	1
2 Other Care for Outpatients				2
3 Governmental Sponsored Special Programs				3
4 Non-Patient Meals	(2,582)	27		4
5 Telephone, TV & Radio in Resident Rooms				5
6 Rented Facility Space				6
7 Sale of Supplies to Non-Patients				7
8 Laundry for Non-Patients				8
9 Non-Straightline Depreciation				9
10 Interest and Other Investment Income	(895)	32		10
11 Discounts, Allowances, Rebates & Refunds				11
12 Non-Working Officer's or Owner's Salary				12
13 Sales Tax				13
14 Non-Care Related Interest				14
15 Non-Care Related Owner's Transactions				15
16 Personal Expenses (Including Transportation)				16
17 Non-Care Related Fees				17
18 Fines and Penalties				18
19 Entertainment				19
20 Contributions				20
21 Owner or Key-Man Insurance				21
22 Special Legal Fees & Legal Retainers				22
23 Malpractice Insurance for Individuals				23
24 Bad Debt				24
25 Fund Raising, Advertising and Promotional				25
26 Income Taxes and Illinois Personal Property Replacement Tax				26
27 Nurse Aide Training for Non-Employees				27
28 Yellow Page Advertising	(525)	20		28
29 Other-Attach Schedule	(16,446)			29
30 SUBTOTAL (A): (Sum of lines 1-29)	\$ (20,448)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

	1	2	
	Amount	Reference	
31 Non-Paid Workers-Attach Schedule*	\$		31
32 Donated Goods-Attach Schedule*			32
33 Amortization of Organization & Pre-Operating Expense			33
34 Adjustments for Related Organization Costs (Schedule VII)			34
35 Other- Attach Schedule	(824)	6	35
36 SUBTOTAL (B): (sum of lines 31-35)	\$ (824)		36
(sum of SUBTOTALS			
37 TOTAL ADJUSTMENTS (A) and (B) )	\$ (21,272)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

	1	2	3	4	
	Yes	No	Amount	Reference	
38 Medically Necessary Transport.		x	\$		38
39					39
40 Gift and Coffee Shops		x			40
41 Barber and Beauty Shops		x			41
42 Laboratory and Radiology		x			42
43 Prescription Drugs		x			43
44 Exceptional Care Program		x			44
45 Other-Attach Schedule		x			45
46 Other-Attach Schedule		x			46
47 TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Daystar Care Center

ID# 0032045

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Flowers	\$ (834)	21	1
2	Non-Allowable Real Estate Tax	(21)	33	2
3	Transportation Reimbursement	(3,677)	6	3
4	Activity Department Revenue	(1,783)	11	4
5	Meal Income	(10,131)	22	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(16,446)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Daystar Care Center

# 0032045

Report Period Beginning:

01/01/2002

Ending:

12/31/2002

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(4,501)	0	0	0	0	0	0	0	0	0	0	(4,501)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	<b>TOTAL General Services</b>	<b>(4,501)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(4,501)</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,783)	0	0	0	0	0	0	0	0	0	0	(1,783)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	<b>TOTAL Health Care and Programs</b>	<b>(1,783)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(1,783)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(525)	0	0	0	0	0	0	0	0	0	0	(525)	20
21	Clerical & General Office Expenses	(834)	0	0	0	0	0	0	0	0	0	0	(834)	21
22	Employee Benefits & Payroll Taxes	(10,131)	0	0	0	0	0	0	0	0	0	0	(10,131)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(2,582)	0	0	0	0	0	0	0	0	0	0	(2,582)	27
28	<b>TOTAL General Administration</b>	<b>(14,072)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(14,072)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(20,356)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(20,356)</b>	<b>29</b>



VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☒ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger	4 Amount	5 Cost to Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
			Item		Name of Related Organization				
1	V			\$			\$	\$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			\$			\$	\$ *	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Daystar Care Center # 0032045 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME,  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Daystar Care Center# 0032045 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

Name of Related Organization \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 City / State / Zip Code \_\_\_\_\_  
 Phone Number ( ) \_\_\_\_\_  
 Fax Number ( ) \_\_\_\_\_

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related Long-Term												
1	USDA, Rural Development		X	Construct Building	\$15,515.00	9/23/91	\$ 2,217,773	\$ 1,125,199	9/23/17	7.0000	\$ 82,721	1	
2												2	
3												3	
4												4	
5												5	
	Working Capital												
6	Capaha Bank		X	line of Credit		various	65,000	24,942	2/22/03	6.2500	5,185	6	
7	Interest Income										(895)	7	
8												8	
9	TOTAL Facility Related				\$15,515.00		\$ 2,282,773	\$ 1,150,141			\$ 87,011	9	
	B. Non-Facility Related*												
10												10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$	14	
15	TOTALS (line 9+line14)						\$ 2,282,773	\$ 1,150,141			\$ 87,011	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ \_\_\_\_\_ Line # \_\_\_\_\_

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.) SEE ACCOUNTANTS' COMPILATION REPORT

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

Facility Name & ID Number **Daystar Care Center**# **0032045** Report Period Beginning: **01/01/2002** Ending: **12/31/2002****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2001 report.		<b>Important</b> , please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$ <b>21</b>	2
3. Under or (over) accrual (line 2 minus line 1).			\$ <b>21</b>	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. <b>(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)</b>			\$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. <b>TOTAL REFUND \$ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)</b>			\$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.			\$ <b>21</b>	7
Real Estate Tax History:				
Real Estate Tax Bill for Calendar Year:	1997	8		
	1998	9		
	1999	17	10	
	2000	19	11	
	2001	20	12	
			13	FOR OHF USE ONLY
			13	FROM R. E. TAX STATEMENT FOR 2001 \$
			14	PLUS APPEAL COST FROM LINE 5 \$
			15	LESS REFUND FROM LINE 6 \$
			16	AMOUNT TO USE FOR RATE CALCULATION \$

**NOTES:**

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

SEE ACCOUNTANTS' COMPILATION REPORT

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2001 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME Daystar Care Center COUNTY Alexander

FACILITY IDPH LICENSE NUMBER 0032045

CONTACT PERSON REGARDING THIS REPORT Amy Keistler

TELEPHONE 618-734-1700 FAX #: 618-734-2611

**A. Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>3379</u>	<u>Lot 1 Kobler's Addition</u>	\$ <u>21.00</u>	\$ <u>21.00</u>
2. _____	_____	\$ _____	\$ _____
3. _____	_____	\$ _____	\$ _____
4. _____	_____	\$ _____	\$ _____
5. _____	_____	\$ _____	\$ _____
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u>21.00</u>	\$ <u>21.00</u>

**B. Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?        YES   X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C. Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,356
 B. General Construction Type:
 Exterior Wood Frame Wood Number of Stories 1

C. Does the Operating Entity?
 ☒ (a) Own the Facility
 ☐ (b) Rent from a Related Organization.
 ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?
 ☒ (a) Own the Equipment
 ☐ (b) Rent equipment from a Related Organization.
 ☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

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F. Does this cost report reflect any organization or pre-operating costs which are being amortized?
 ☐ YES ☒ NO

If so, please complete the following:

1. Total Amount Incurred:
 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:
 4. Dates Incurred:

Nature of Costs:
 (Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Building Site	139,264	10/12/1995	\$ 27,200	1
2	Vacant	3,513	8/1/1997	200	2
3	TOTALS	142,777		\$ 27,400	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name &amp; ID Number Daystar Care Center

# 0032045

Report Period Beginning:

01/01/2002 Ending: 12/31/2002

**XL OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	83		1987	1987	\$ 1,148,065	\$ 38,269	30	\$ 38,269	\$	\$ 589,978	4
5			1991	1991	(10,658)	(402)	26.5	(402)		(4,770)	5
6			1994	1994	3,500	152	23	152		1,369	6
7											7
8											8
	<b>Improvement Type**</b>										
9	Heating System		1987	1987	160,880	8,044	20	8,044		124,012	9
10	Piping & Plumbing		1987	1987	176,139	7,046	25	7,046		108,620	10
11	Ventilation Fans		1987	1987	8,120	316	15	316		8,120	11
12	Fixtures		1987	1987	45,875	2,294	20	2,294		35,363	12
13	Sprinkler System		1987	1987	41,220	1,649	25	1,649		25,419	13
14	Wiring		1987	1987	170,162	8,508	20	8,508		131,166	14
15	Diesel Generator		1987	1987	25,254	1,263	20	1,263		19,467	15
16	Fire Alarm System		1987	1987	12,529	626	20	626		9,657	16
17	Paging, Alarm and TV		1987	1987	19,705	1,314	15	1,314		20,253	17
18	Sign		1987	1987	2,554		12			2,554	18
19	Landscaping		1987	1987	7,500		10			7,500	19
20	Walks, Patios, Curbs		1987	1987	15,709	785	20	785		12,108	20
21	Telephone System		1987	1987	12,889	644	20	644		9,934	21
22	Patio		1988	1988	16,738	837	20	837		11,856	22
23	Storage Shed		1988	1988	2,054	103	20	103		1,516	23
24	Air Condition Window Unit		1990	1990	953		8			953	24
25	Patio		1991	1991	2,611	131	20	131		1,469	25
26	Magic Air Handling Unit		1991	1991	2,241		10			2,241	26
27	Telephone System		1991	1991	1,583		10			1,583	27
28	Gazebo		1992	1992	3,575	179	20	179		1,803	28
29	Gazebo Landscaping		1992	1992	1,180	49	10	49		1,180	29
30	Heating and Air Conditioning Unit		1992	1992	1,839	123	15	123		1,268	30
31	Awning for Building		1993	1993	2,500		10			2,500	31
32	Water Heaters (2)		1995	1995	8,063	539	15	539		4,058	32
33	Enrty Access System		1996	1996	2,883	288	10	288		1,801	33
34	Water Heaters (2)		1995	1995	8,063	539	15	539		8,602	34
35	Boiler Shell		1996	1996	2,525	252	10	252		1,577	35
36	Parking Lot Blacktop		1997	1997	8,400	420	20	420		2,450	36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

**XI. OWNERSHIP COSTS (continued)**

**B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	A/C Conditioner Condensers (2)	1998	\$ 3,386	\$ 339	10	\$ 339	\$	\$ 1,581		37
38	Quarry Tile Floor	2000	14,041	936	15	936		2,652		38
39	Surveillance System	2000	1,846	369	5	369		984		39
40	Door to Boiler Room	2000	504	72	7	72		192		40
41	Camera System-Alz. Unit	2000	1,200	171	7	171		413		41
42	Compressor	2001	2,375	238	10	238		396		42
43	Hot Water Heater	2001	6,199	413	15	413		516		43
44	Alzheimer's Unit	2002	80,070	500	40	500		500		44
45										45
46										46
47										47
48										48
49										49
50										50
51										51
52										52
53										53
54										54
55										55
56										56
57										57
58										58
59										59
60										60
61										61
62										62
63										63
64										64
65										65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 2,014,272	\$ 77,006		\$ 77,006	\$	\$ 1,152,841		70

SEE ACCOUNTANTS' COMPILATION REPORT

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 333,285	\$ 23,449	\$ 23,449	\$	3-20	\$ 268,004	71
72	Current Year Purchases	7,357	541	541		5	541	72
73	Fully Depreciated Assets	74,684				5-10	74,684	73
74								74
75	TOTALS	\$ 415,326	\$ 23,990	\$ 23,990	\$		\$ 343,229	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	2000 Dodge	2001	\$ 30,903	\$ 5,666	\$ 5,666	\$	5	\$ 11,846	76
77										77
78										78
79										79
80	TOTALS			\$ 30,903	\$ 5,666	\$ 5,666	\$		\$ 11,846	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,487,901	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 106,662	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 106,662	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,507,916	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

**If NO, see instructions.**

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	<b>TOTAL</b>		\$	\$	21

12.	<u>          </u>	/2003	\$	<u>          </u>
13.	<u>          </u>	/2004	\$	<u>          </u>
14.	<u>          </u>	/2005	\$	<u>          </u>

**\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.**

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p> <input type="checkbox"/> YES      <input checked="" type="checkbox"/> NO                 </p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		1		2		3	4
		Facility					
		Drop-outs	Completed	Contract	Total		
1	Community College Tuition	\$	\$	\$	\$		
2	Books and Supplies						
3	Classroom Wages (a)						
4	Clinical Wages (b)						
5	In-House Trainer Wages (c)						
6	Transportation						
7	Contractual Payments						
8	Nurse Aide Competency Tests						
9	TOTALS	\$	\$	\$	\$		
10	SUM OF line 9, col. 1 and 2 (e)	\$					

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
 (c) For in-house training programs only. Do not include fringe benefits.  
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.  
 SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	\$		\$	\$		\$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
10	Academic Education		hrs							11
11	Exceptional Care Program									12
12	Other (specify):									13
13										
14	TOTAL			\$		\$	\$		\$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Daystar Care Center

# 0032045

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2002

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ 23,238	\$	1
2	Cash-Patient Deposits	4,603		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance )	397,479		3
4	Supply Inventory (priced at )	7,055		4
5	Short-Term Investments			5
6	Prepaid Insurance	2,775		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	<b>TOTAL Current Assets (sum of lines 1 thru 9)</b>	\$ 435,150	\$	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	27,400		13
14	Buildings, at Historical Cost	2,002,823		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	457,678		16
17	Accumulated Depreciation (book methods)	(1,507,916)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	160,218		21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets (sum of lines 11 thru 23)</b>	\$ 1,140,203	\$	24
25	<b>TOTAL ASSETS (sum of lines 10 and 24)</b>	\$ 1,575,353	\$	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 175,329	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	4,603		28
29	Short-Term Notes Payable	69,463		29
30	Accrued Salaries Payable	38,557		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable	6,258		33
34	Deferred Compensation	28,879		34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Misc. Employee Withholdings	147		36
37	<b>Current Portion Long-Term Debt</b>	110,930		37
38	<b>TOTAL Current Liabilities (sum of lines 26 thru 37)</b>	\$ 434,166	\$	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable	1,014,270		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities (sum of lines 39 thru 44)</b>	\$ 1,014,270	\$	45
46	<b>TOTAL LIABILITIES (sum of lines 38 and 45)</b>	\$ 1,448,436	\$	46
47	<b>TOTAL EQUITY(page 18, line 24)</b>	\$ 126,917	\$	47
48	<b>TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)</b>	\$ 1,575,353	\$	48

SEE ACCOUNTANTS' COMPILATION REPORT

\*(See instructions.)

**XVI. STATEMENT OF CHANGES IN EQUITY**

		<b>1</b> <b>Total</b>	
<b>1</b>	<b>Balance at Beginning of Year, as Previously Reported</b>	<b>\$ 258,984</b>	<b>1</b>
<b>2</b>	Restatements (describe):		<b>2</b>
<b>3</b>	<b>Prior Period Adjustment-IDPA Overpayments</b>	<b>(66,783)</b>	<b>3</b>
<b>4</b>			<b>4</b>
<b>5</b>			<b>5</b>
<b>6</b>	<b>Balance at Beginning of Year, as Restated (sum of lines 1-5)</b>	<b>\$ 192,201</b>	<b>6</b>
	<b>A. Additions (deductions):</b>		
<b>7</b>	NET Income (Loss) (from page 19, line 43)	<b>(65,284)</b>	<b>7</b>
<b>8</b>	Aquisitions of Pooled Companies		<b>8</b>
<b>9</b>	Proceeds from Sale of Stock		<b>9</b>
<b>10</b>	Stock Options Exercised		<b>10</b>
<b>11</b>	Contributions and Grants		<b>11</b>
<b>12</b>	Expenditures for Specific Purposes		<b>12</b>
<b>13</b>	Dividends Paid or Other Distributions to Owners	<b>( )</b>	<b>13</b>
<b>14</b>	Donated Property, Plant, and Equipment		<b>14</b>
<b>15</b>	Other (describe)		<b>15</b>
<b>16</b>	Other (describe)		<b>16</b>
<b>17</b>	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	<b>\$ (65,284)</b>	<b>17</b>
	<b>B. Transfers (Itemize):</b>		
<b>18</b>			<b>18</b>
<b>19</b>			<b>19</b>
<b>20</b>			<b>20</b>
<b>21</b>			<b>21</b>
<b>22</b>			<b>22</b>
<b>23</b>	<b>TOTAL Transfers (sum of lines 18-22)</b>	<b>\$</b>	<b>23</b>
<b>24</b>	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	<b>\$ 126,917</b>	<b>24 *</b>

\* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.  
**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

		1	
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 2,598,633	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 2,598,633	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	13,481	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	10,132	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 23,613	23
<b>D. Non-Operating Revenue</b>			
24	Contributions	1,536	24
25	Interest and Other Investment Income***	5,140	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 6,676	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	<b>Activities Income</b>	1,784	28
28a	<b>Patient Transportation</b>	3,677	28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 5,461	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 2,634,383	30

		2	
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	594,537	31
32	Health Care	1,406,205	32
33	General Administration	451,304	33
<b>B. Capital Expense</b>			
34	Ownership	194,589	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	7,589	35
36	Provider Participation Fee	45,443	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 2,699,667	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(65,284)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (65,284)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. **SEE ACCOUNTANTS' COMPILATION REPORT**

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name &amp; ID Number Daystar Care Center

# 0032045

Report Period Beginning: 01/01/2002

Ending:

12/31/2002

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,815	1,937	\$ 35,745	\$ 18.45	1
2	Assistant Director of Nursing					2
3	Registered Nurses	2,831	2,951	52,449	17.77	3
4	Licensed Practical Nurses	18,451	20,081	277,286	13.81	4
5	Nurse Aides & Orderlies	66,871	71,048	558,431	7.86	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,189	7,880	72,876	9.25	7
8	Rehab/Therapy Aides					8
9	Activity Director	1,615	1,821	20,919	11.49	9
10	Activity Assistants	3,019	3,409	28,288	8.30	10
11	Social Service Workers	3,434	3,785	42,311	11.18	11
12	Dietician					12
13	Food Service Supervisor	2,294	2,454	20,263	8.26	13
14	Head Cook	1,720	1,916	16,180	8.44	14
15	Cook Helpers/Assistants	13,562	14,374	99,833	6.95	15
16	Dishwashers					16
17	Maintenance Workers	2,972	3,234	36,112	11.17	17
18	Housekeepers	10,301	11,457	88,343	7.71	18
19	Laundry	7,446	8,036	56,274	7.00	19
20	Administrator	1,786	1,947	39,379	20.23	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,762	9,760	112,332	11.51	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,435	2,594	24,134	9.30	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	156,503	168,684	\$ 1,581,155 *	\$ 9.37	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	155	\$ 6,675	1-3	35
36	Medical Director	120	3,600	9-3	36
37	Medical Records Consultant	12	1,920	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12	600	15-3	39
40	Physical Therapy Consultant	2,331	116,569	10a-3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	107	3,224	12-3	45
46	Other(specify) Doctor	120	3,600	15-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	2,857	\$ 136,188		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

## **XIX. SUPPORT SCHEDULES**

A. Administrative Salaries			
Name	Function	%	Amount
Amy Keistler	Administrator		\$ 39,379
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			\$ 39,379
B. Administrative - Other			
Description			Amount
			\$
TOTAL (agree to Schedule V, line 17, col. 3)			\$
(Attach a copy of any management service agreement)			
C. Professional Services			
Vendor/Payee	Type		Amount
Keane Computer Care	Computer Maintenance	\$	6,641
Mark Johnson	Legal Fees		1,462
BHRSS, LLC	Audit		6,000
BHRSS, LLC	Monthly GL Service		3,942
BHRSS, LLC	Cost Report		6,054
BHRSS, LLC	Budget		300
Medinet	Medicare Billing		200
Ivan's	Medicare Billing		129
Computer Solutions	Computer Maintenance		35
Earthlink	Internet Service		263
TOTAL (agree to Schedule V, line 19, column 3)			
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 25,026
D. Employee Benefits and Payroll Taxes			
Description			Amount
Workers' Compensation Insurance		\$	28,045
Unemployment Compensation Insurance			396
FICA Taxes			119,428
Employee Health Insurance			
Employee Meals			38,300
Illinois Municipal Retirement Fund (IMRF)*			
Other Employee Benefits			4,190
Meal Income			(10,131)
TOTAL (agree to Schedule V, line 22, col.8)		\$	180,228
E. Schedule of Non-Cash Compensation Paid to Owners or Employees			
Description	Line #		Amount
		\$	
TOTAL		\$	
F. Dues, Fees, Subscriptions and Promotions			
Description			Amount
IDPH License Fee		\$	
Advertising: Employee Recruitment			695
Health Care Worker Background Check (Indicate # of checks performed _____)			
Advertising			899
Dues & Subscriptions			6,655
Less: Public Relations Expense		(	
Non-allowable advertising		(	
Yellow page advertising			(525)
TOTAL (agree to Sch. V, line 20, col. 8)		\$	7,724
G. Schedule of Travel and Seminar**			
Description			Amount
Out-of-State Travel		\$	
Within 50 miles for Patient Care			600
In-State Travel			914
Inservice Training			
Seminar Expense			1,359
Entertainment Expense		(	
(agree to Sch. V, line 24, col. 8)			
TOTAL		\$	2,873

\* Attach copy of IMRF notifications  
SEE ACCOUNTANTS' COMPILATION REPORT

**\*\*See instructions.**

**XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS** (which have been included in Sch. V, line 6, col. 3).  
 (See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	Repair Tile - Bathroom	10-94	\$ 5,910	10	\$ 591	\$ 591	\$ 591	\$ 591	\$ 591	\$ 493	\$	\$	\$
2	Repair - Generator	2-96	2,325	10	233	233	233	233	233	233	233	15	
3													
4													
5													
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17													
18													
19													
20	TOTALS		\$ 8,235		\$ 824	\$ 824	\$ 824	\$ 824	\$ 824	\$ 726	\$ 233	\$ 15	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Daystar Care Center

STATE OF ILLINOIS

# 0032045

Report Period Beginning: 01/01/2002

Page 23

Ending: 12/31/2002

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? No
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. Ill. Assoc. of Homes for the Aging
- (3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? \_\_\_\_\_
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 5
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ None Line \_\_\_\_\_
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation. \_\_\_\_\_
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over. \_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 45,443  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation. \_\_\_\_\_

SEE ACCOUNTANTS' COMPILATION REPORT

- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? None
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 38,300 Has any meal income been offset against related costs? Yes Indicate the amount. \$ 10,131
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? Yes  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? Yes If YES, please indicate the amount of income earned from such a program during this reporting period. \$ 3,677  
c. What percent of all travel expense relates to transportation of nurses and patients? \_\_\_\_\_  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? None  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? Yes  
Firm Name: Beussink, Hey, Roe, Seabaugh & Stroder, LLC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? Yes If no, please explain. \_\_\_\_\_
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? None
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? N/A  
Attach invoices and a summary of services for all architect and appraisal fees.